BRITISH COLUMBIA

Ref #: 234875
Date: December 2018

SUMMARY: FILE REVIEW
Of the Death of a Child Known to the Ministry in 2017

A. INTRODUCTION

The Ministry of Children and Family Development (the ministry) conducted the File Review (FR) to examine the case practice and services provided to the subject child (the child) of the FR.

For the purposes of the FR, ministry records were reviewed. The focus of the FR was the period of ministry involvement prior to the death of the child.

B. TERMS OF REFERENCE

1. Did the ministry appropriately assess the child's safety, particularly as it related to concerns of a specific issue and a high-risk issue with regards to the parents?

2. Was an appropriate family plan developed, implemented and monitored to adequately address the child's safety and well-being?

C. BACKGROUND SUMMARY

The ministry had previous involvement with the family due to concerns about high-risk issues, and a specific issue. The ministry responded to several reports regarding the welfare of the child and had ongoing involvement with the family. The child, who was Indigenous, was not in care at the time of death.

D. FINDINGS

1. The ministry partially assessed the child's safety. The initial assessment and response were appropriate; however, the subsequent planning was not adequate to protect the child. The lack of completion of the tools and checklists required to measure risk contributed to the child being left in the care of her parents, with whom the ministry had concerns. While practice issues did not directly relate to the incident, it was clear the ministry did not adequately monitor the family or reassess the risk to ensure the child's safety.

2. A family plan was not developed and, therefore, a gap existed with ensuring that the child's safety and well-being was adequately assessed. The ministry did not initiate the assessment required to inform the plan. The organizational learning from the circumstances of the case is the requirement of the completion of the tools required to inform service delivery and practice.

E. ACTIONS TAKEN TO DATE

1. The Director of Operations met with the involved staff to debrief the incident. As part of the debrief, the Director of Operations reviewed the use of SDM tools, and the team leader has since developed a tracking tool for SDM completion with all involved staff.

F. ACTION PLAN

1. Provide a refresher on domestic violence training to the involved ministry staff which highlights the use of the domestic violence risk factors in assessing child safety and informing a family plan.

The review was completed in June 2018. The above action plan was due for full implementation in September 2018.